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Geriatric Medicine - A Clinical Imperative (condensed)

Five percent of the Medicare population consumes 50 percent of the Medicare dollars - many of these "high consumers" are the frail elderly.

Chronic diseases such as diabetes and heart disease are the major cause of illness, disability, and death in this country, accounting currently for 75 percent of all deaths and **80 percent of all health resources used**.

A number of reports have been written on the need for increased geriatric training for physicians and other providers in order to meet the coming baby boom, beginning with the Institute of Medicine (IOM) in 1978. Progress has been made, but as the IOM more recently noted, progress remains insufficient.

The Medicare program has just undergone major reform. At the same time, **these changes do not fully address the needs of the frail elderly as they lack a physician-oriented chronic care delivery program for the frail elderly.**

"Do all patients need a geriatrician, just as most children regularly see a pediatrician?" The answer is no. Both work force realities and patient needs mean that a small portion of the Medicare population should access a geriatrician. Approximately 15 percent of community dwelling Medicare beneficiaries need access to a geriatrician or geriatric services provided by a primary care physician. In addition, residents of nursing homes and other congregate care facilities need access to quality, geriatric care.

Twenty percent of the Medicare population has at least five chronic conditions, accounting for two thirds of total program spending. These beneficiaries see on average 14 different/unique physicians in a year and have about thirty-seven office visits. Average annual prescriptions filled increased from 3.7 for all people studied with no chronic conditions to 49.2 for people with five or more chronic conditions. Fifty-five percent of these beneficiaries experience an inpatient hospital stay compared to five percent for those with one condition or nine percent for those with two conditions. Access to quality, geriatric care could decrease inpatient utilization.

Over the past ten years, peer reviewed literature has strongly supported geriatric care systems and have demonstrated the following **benefits of geriatric care**:

- **preservation of physical function or slowing of decline**;
- Dramatically increased patient and family **satisfaction**;
- **decreased time spent in an inpatient setting** such as a hospital or nursing home;
- **improved social functioning** in the community;
- **decreased rates of depression**;
- **increased access to social support services**; and
- **reduced disability**

Our nation faces a severe and worsening shortage of geriatricians, both in the area of clinical and academic geriatrics.

Office visits by geriatric patients comprise about 40 percent of the average internists' practice and about one quarter of all visits to family physicians.

Despite the small but growing numbers of physicians selecting geriatrics as a career, practicing geriatricians reported unusually high job satisfaction in a recent study.

If there is a well-documented need for geriatricians and the job is satisfying, why aren't more physicians going into geriatrics?

Geriatricians are almost entirely **dependent on Medicare revenues**, given their patient caseload. The IOM and MedPAC identified **low Medicare reimbursement levels as a major reason for inadequate recruitment into geriatrics**. Because of the complexity of care needed and the time required to deliver quality care, Medicare payment policies currently provides a disincentive for physicians to enter the field of geriatrics and to carry a full caseload of Medicare beneficiaries who are frail and chronically ill.

Little is being done to change the nature of the system from acute episode care to sustained chronic care. The Medicare bill included several new chronic care provisions, including a new study on chronic care, a small scale physician-oriented demonstration program, and a larger scale disease management pilot program. However, the new disease management program may not adequately address the needs of persons with multiple chronic conditions (multiple chronic conditions, disruption of patient-PCP relationship, not accounting for dementia or other age-related obstacles, not addressing functional issues).

What are some solutions?

In addition to certified geriatricians, there is a need for increased geriatric training and awareness in other physician specialties and other health professions.

1. Medicare Payment:

First, Medicare should cover geriatric assessment and care coordination services. **Second**, Medicare should develop and implement a risk adjuster to account for the time and complexity involved with treating a frail elderly patient where a physician's practice has a high number of these patients.

2. Medical Education Loan Forgiveness:

The Public Health Service and/or the National Institutes of Health could provide loan forgiveness to individuals who get a CAQ in geriatrics. This strategy has been used in other work force shortage areas in the past.

3. Graduate Medical Education Changes:

Policy makers should provide for further limited changes in this area by authorizing a limited waiver in the per hospital cap for geriatric trainees.

4. Provide adequate funding for Title VII geriatrics programs:

In recent years, Congress has increased funding for these geriatric health professions programs. Congress should continue these important increases, and are up for Congressional reauthorization this year.

5. Institute incentives for medical schools, as well as professional schools, to incorporate geriatrics into training programs.

6. Medicare Chronic Illness Care Programs:

CMS should critically evaluate the outcomes of the new chronic care improvement organizations (CCIO) programs in elderly populations with multiple chronic conditions. Another smaller demonstration authorizes a physician-based pay for performance model. Congress should further explore the value of the pay for performance model in improving patient care and adequately reimbursing physicians for information technology and other related care management expenses.

7. Medicare and/or Medicaid Certified Nursing Homes:

CMS could modify conditions of participation so that a certain percentage of staff would have to have completed some type of geriatric training.